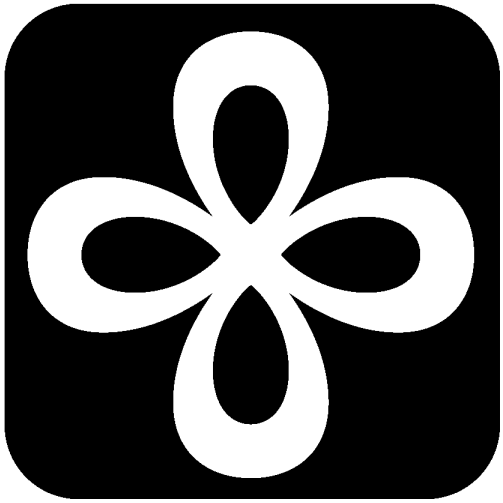
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

MEDICAID



Provider Manual

Podiatric Services

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APPENDIX

I. CONDITIONS FOR PARTICIPATION

All doctors of podiatry licensed to practice in the state of Iowa are eligible to participate in the Medicaid Program. Doctors of podiatry in other states are also eligible to participate providing they are duly licensed in that state.

II. COVERAGE OF SERVICES

Payment will be made for the same scope of podiatric services available through Part B of Medicare, except as outlined below.

A. Orthopedic Shoes

Payment will be made for the examination to establish the need for orthopedic shoes, including required tests. On all claims containing a charge for such service, indicate the date the shoes were prescribed, the diagnosis, and the reason orthopedic shoes are needed.

Payment will not be made to a doctor of podiatry for orthopedic shoes other than for custom-made shoes. Payment will be made to orthopedic shoe dealers for orthopedic shoes prescribed in writing by a doctor of podiatry. A prescription for custom-made shoes must include the diagnosis. The shoe dealer has been directed to return the prescription for custom-made shoes to prescriber when the diagnosis has been omitted.

Payment will also be made to the shoe repair shop for modifications of orthopedic shoes (padding, wedging, metatarsal bars, built-up soles or heels, etc.) prescribed in writing by a doctor of podiatry.

No payment will be approved for two pairs of shoes purchased at the same time, except when the second pair is:

- Tennis shoes need to meet educational requirements, or
- Shoes prescribed for a medically related reason; e.g., to attach night braces.

The reason for the exception must be written on the prescription.

B. Orthotic Appliances

In addition to Medicare-covered services, payment will be approved for certain orthotic appliances, as follows:

- Durable plantar foot orthotic
- Plaster impressions for foot orthotic
- Molded digital orthotic
- Shoe padding (when appliances are not practical, e.g., for a young, rapidly growing child, but not limited to children)
- Custom-made shoes (only for severe rheumatoid arthritis, congenital defects and deformities, neurotrophic, diabetic and ischemic intractable ulcerations and deformities due to injuries. Includes impression.)

No payment will be made for the dispensing of two pair of orthotic appliances at the same time.

C. Radiological and Pathological Services

Payment will be made for X-ray and laboratory tests which are reasonable and necessary for the diagnosis or treatment of a patient's condition and are not in connection with excluded services.

D. Routine Foot Care

Routine foot care includes the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot.

Routine foot care is not a covered service. Foot care such as routine soaking and application of topical medication on a physician's order between required visits to the physician is not covered. **Note:** Payment will be made for removal of warts.

The nonprofessional performance of certain foot care procedures otherwise considered routine, such as cutting or removal of corns, calluses or nails, can present a hazard to people with certain diseases. If a procedure does present a hazard to the patient, it is not considered routine when the patient is under the care of a doctor of medicine or osteopathy.

The requirement for coverage of routine foot care is that a patient have one of the following diagnoses:

- Arteriosclerosis obliterans (A.S.O. arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease
- Chronic thrombophlebitis *
- Diabetes mellitus *
- Peripheral neuropathies involving the feet associated with: *
  - Alcoholism
  - Arcinoma
  - Drugs and toxins
  - General and pellagra malnutrition
  - Leprosy or neurosyphilis
  - Malabsorption (celiac disease, tropical sprue)
  - Multiple sclerosis
  - Pernicious anemia
  - Traumatic injury
  - Uremia
  - Hereditary disorders:
    - Angiokeratoma corporis diffusm (Fabry's)
    - Amyloid neuropathy
    - Hereditary sensory radicular neuropathy

***** If the diagnosis is followed by an asterisk (*), the claim must also include the following:

- The name of the attending physician, either an M.D. or O.D.
- The date of the patient's last visit to the attending physician within the last six months, or the date of a planned future visit within one month.

E. Treatment of Nail Pathologies

In addition to Medicare-covered services, payment will be approved for certain treatment of nail pathologies, as follows:

- Excision of nail and nail matrix, partial or complete for permanent removal
- Excision of nail simple (i.e., ingrown or deformed) without permanent removal
- Debridement of nails for:
  - Persons under active treatment by a physician (MD or DO) for certain diseases
  - Rams horn (hypertrophied) nails
  - Onychomycosis (mycotic) nails

See Section V for procedure codes for these services.

F. Treatment of Pes Planus

Pes planus is defined as a condition in which one or more arches have flattened out. Services directed toward the care or correction of pes planus are not covered, except when treated by orthotic appliances listed above in item B, or by orthopedic shoes, as spelled out in item A.

G. Treatment of Subluxations of the Foot

Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered. (Exception: See item A, ***Orthopedic Shoes***.)

Reasonable and necessary diagnosis and treatment of symptomatic conditions, such as osteoarthritis, bursitis (including bunion), tendinitis, etc., that result from or are associated with partial displacement of foot structures are covered services.

Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury is a covered service when it is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition.

III. PRESCRIPTION OF DRUGS AND MEDICAL SUPPLIES

Payment will be made only for legend drugs and a limited number of nonlegend drugs prescribed by a doctor of podiatry. (Payment will not be made for drugs classified as less than effective by the Food and Drug Administration.)

A written prescription is required for all supplies. Place your provider number on the prescription. A new prescription for shoes and supplies is required on each occasion.

Payments will be made for drugs dispensed by a podiatrist only when the podiatrist's office is located in a community that has no licensed retail pharmacy. If you are eligible to dispense drugs by this policy, request a copy of the Prescribed Drugs Manual from the fiscal agent.

Payment will not be made for writing prescriptions.

A. Legend Drugs and Devices

Payment will be made for drugs and devices requiring a prescription by law, with the following exceptions:

- Drugs not marketed by manufacturers that have a signed Medicaid rebate agreement
- Drugs prescribed for a use other than the drug's medically accepted use
- Drugs used to cause anorexia or weight gain
- Drugs used for cosmetic purposes or hair growth
- Drugs used to promote smoking cessation
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee
- Drugs classified as "less than effective" by the Food and Drug Administration

B. Nonlegend Drugs

Payment for the following listed drugs will be made in the same manner as for prescription drugs, except that a maximum allowable cost (MAC) is established at the median of the average wholesale prices of the chemically equivalent products available. Current maximum allowable costs are listed below. No exceptions for reimbursement for higher cost products will be approved.

	MAC PER TABLET OR ML
Acetaminophen tablets, 325 mg	$.0156
Acetaminophen tablets, 500 mg	.0225
Acetaminophen elixir, 120 mg/5 ml	.0039
Acetaminophen elixir, 160 mg/5 ml	.0061
Acetaminophen solution, 100 mg/ml	.1693
Acetaminophen suppositories, 120 mg	.4575
Aspirin, 81 mg	.0497
Aspirin tablets, 325 mg	.0099
Aspirin tablets, 650 mg	.0287
Aspirin tablets, enteric coated, 325 mg	.0197
Aspirin tablets, enteric coated, 650 mg	.0263
Aspirin tablets, buffered, 325 mg	.0170
Bacitarcin ointment, 500 Unit/GM	.0880
Benzoyl peroxide 5% gel	.0422
Benzoyl peroxide 5% lotion	.0537
Benzoyl peroxide 5% wash	.0632
Benzoyl peroxide 10% gel	.0440
Benzoyl peroxide 10% lotion	.0550
Benzoyl peroxide 10% wash	.0676
Chlorpheniramine maleate, tablet, 4 mg	.0103
Ferrous sulfate tablets, 300 mg	.0147
Ferrous sulfate tablets, 325 mg	.0147
Ferrous sulfate elixir, 220 mg/5 ml	.0050
Ferrous sulfate drops, 75 mg/0.6 ml	.0388
Ferrous gluconate tablets, 320 mg	.0159
Ferrous gluconate tablets, 325 mg	.0149

Ferrous gluconate elixir, 300 mg/5 ml	$.0138
Ferrous fumarate tablets, 300 mg	.0152
Ferrous fumarate tablets, 325 mg	.0159
Niacin, 50 mg tablets	.0175
Niacin, 100 mg tablets	.0195
Niacin, 250 mg tablets	.0360
Niacin, 500 mg tablets	.0284
Pediatric oral electrolyte solutions	.0054
Permethrin liquid	.1363
Pseudoephedrin syrup, 30 mg/5 ml	.0200
Pseudoephedrine tablets, 30 mg	.0210
Pseudoephedrine tablets, 60 mg	.0410
Sodium chloride solution, 0.9% for inhalation with metered dispensing value	.0451
Tolnaftate 1% cream	.1167
Tolnaftate 1% powder	.0700
Tolnaftate 1% solution	.2290

Also payable are:

- Nonlegend multiple vitamin and mineral products specifically formulated and recommended for use as a dietary supplement during pregnancy and lactation.
- With prior authorization, nonlegend multiple vitamins and minerals under certain conditions.

Oral solid forms of these covered items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription, except when dispensed via a unit-dose system. When used for maintenance therapy, all of these items may be prescribed and dispensed in 90-day quantities.

Payment for drug products which have lower-cost equivalents available shall be limited to the average wholesale price of the equivalent product dispensed. Equivalent products shall be defined as those products which meet therapeutic equivalence standards as published in the Federal Food and Drug Administration document, “Approved Prescription Drug Products with Therapeutic Equivalence Evaluations.”

If the lower-cost equivalent product is not dispensed in lieu of a more expensive brand-name product, the maximum allowable reimbursable cost shall be established at 150 percent of the average wholesale price of the least costly equivalent product.

Procedures for exceptions to the maximum allowable limit are the same as those in effect for the federal maximum allowable cost program, i.e., the doctor of podiatry certifies in the doctor's own handwriting that in the doctor's medical judgment a specific brand is medically necessary.

C. Injected Medication

Payment will be approved for injections, provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury or are for purposes of immunization. The following information must be provided when billing for injections:

- Brand name of drug and manufacturer
- Strength of drug
- Amount administered
- Charge for each injection

When the strength and dosage information is not provided, claims will be denied. This information is not needed if it has been specified in the HCPC code.

For injections related to diagnosis or treatment of illness or injury, following specific exclusions are applicable:

1. Injections Not Indicated for Treatment of a Particular Condition

Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered. The Vitamin B-12 injection is an example. Medical practice generally calls for use of this injection when various physiological mechanisms produce a vitamin deficiency. Use of Vitamin B-12 in treating any unrelated condition will result in a disallowance.

2. Injections Not for a Particular Illness

Payment will not be approved for an injection if administered for a reason other than the treatment of a particular condition, illness or injury.

NOTE: You must obtain prior approval before employing an amphetamine or legend vitamin by injection. (See Item B.)

3. Method of Injection Not Indicated

Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

4. Allergenic Extract Injection

Claims from suppliers of allergenic extract materials provided the patient for self-administration will be allowed according to coverage limits in effect for this service.

5. Excessive Injections

Basic standards of medical practice provide guidance as to the frequency and duration of injections. These vary and depend upon the required level of care for a particular condition. The circumstances must be noted on the claim before additional payment can be approved.

When excessive injections appear, representing a departure from accepted standards of medical practice, the entire charge for injection given in excess of these standards will be excluded. For example, such an action might occur when Vitamin B-12 injections are given for pernicious anemia more frequently than the accepted intervals.

If an injection is determined to fall outside of what is medically reasonable or necessary, the entire charge (i.e., for both the drug and its administration) will be excluded from payment. Therefore, if a charge is made for an office visit primarily for the purpose of administering drugs, it will be disallowed along with the noncovered injections.

D. Drugs Requiring Prior Approval of the Fiscal Agent

The following drugs require a prior authorization through the fiscal agent:

- Histamine H_2-receptor antagonists and sucralfate at full therapeutic dose
- Omeprazole
- Misoprostol
- Single-source non-steroidal anti-inflammatory drugs
- Legend and nonlegend multiple vitamins, tonic preparations and combinations with minerals, hormone, stimulants
- Dipyridamole
- Cephalexin hydrochloride monohydrate
- Single-source benzodiazepines
- Legend topical anti-acne products
- Topical tretinoin (Retin A™ products)
- Amphetamines, combinations of amphetamines with other agents, and amphetamine-like sympathomimetic compounds
- Growth hormones
- Clozapine
- Nonsedating antihistamines
- Epoetin (Epogen)
- Filgrastim (Neupogen)

Payment for these drugs will be made only after approval is obtained through the fiscal agent and when the drugs are prescribed for treatment of one or more of the conditions set forth for each drug.

Use the Request For Medicaid Drug Prior Authorization, form 470-2961, for this purpose. The request must state the diagnosis and total medical condition of the patient. You may request prior authorization via telephone, FAX, or mail to the UNISYS Drug Prior Authorization Unit. The request requires the information designated on form 470-2961. Instructions for completing form 470-2961 are found in Chapter F.

The pharmacist reviewer will make a decision and respond within 24 hours of the request. Request received after regular working hours (8:30 AM to 5:30 PM) or on weekends will be considered to be received at the start of the next working day. If the after-hours or weekend request is for an emergency situation, a 72-hour supply may be dispensed and reimbursement will be made.

When you are requiring the pharmacy to request the prior authorization, including the diagnosis on the prescription will facilitate the process. If you request the prior authorization, it is your responsibility to notify the pharmacy of the prior approval number, since the approval is required for processing the pharmacy claim.

Approval needs to be obtained only once for an uninterrupted course of therapy for a patient. An "uninterrupted course of therapy" is considered to be a period in which any discontinuance of the drug is for no longer than seven days. Payment for a prior approved drug will be made to only one pharmacy for a given recipient for an uninterrupted course of therapy.

The specific criteria for approval of a prior authorization request of some of these drugs are defined in the subsections that follow. If you need clarification of these or information on a drug that is not listed, please call the fiscal agent's drug prior authorization number (1-800-998-0392).

1. Histamine H_2-Receptor Antagonists and Sucralfate

Prior authorization is required for histamine H_2-receptor antagonists and sucralfate at full therapeutic dose levels for longer than a 90-day period. Prior authorization is <u>not</u> required for maintenance doses of these drugs or for a cumulative 90 days of therapy at full therapeutic dose levels per 12-month period per recipient.

Payment for full therapeutic dose levels beyond the 90-day limit or more frequently than one 90-day course per recipient per 12-month period will be authorized only for those cases in which there is a diagnosis of:

- Barretts esophagus
- Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas)
- Symptomatic gastroesophageal reflux (not responding or failure by maintenance therapy)
- Symptomatic relapses (duodenum or gastric ulcer) on maintenance therapy
- Other conditions will be considered on an individual basis

Sucralfate prescribed concurrently with histamine H_2-receptor antagonists for a period exceeding 30 days will be considered duplicative and inappropriate. Omeprazole or misoprostol prescribed concurrently with histamine H_2-receptor antagonists will be considered duplicative and inappropriate.

2. Omeprazole

Prior authorization is required for omeprazole at full therapeutic dose levels for longer than 60 days of therapy. Prior authorization is not required for a cumulative 60 days of therapy at full therapeutic dose levels per 12-month period per recipient.

Payment for omeprazole at full therapeutic level beyond the 60-day limit or more frequently than the one 60-day course per recipient per 12-month period will be authorized on an individual basis. Omeprazole prescribed concurrently with histamine H_2-receptor antagonists will be considered duplicative and inappropriate.

3. Misoprostol

Prior authorization is not required when a nonsteroidal anti-inflammatory drugs is prescribed concurrently. Prior authorization is not required for therapy without a concurrent nonsteroidal anti-inflammatory drug for 90 days of therapy.

Prior authorization is required for therapy without a concurrent nonsteroidal anti-inflammatory drug beyond the 90-day limit. Payment will be authorized only on an individual basis. Misoprostol prescribed concurrently with histamine H_2-receptor antagonists will be considered duplicative and inappropriate.

4. Single-Source Nonsteroidal Anti-Inflammatory Drugs

Prior authorization is not required for multiple-source nonsteroidal anti-inflammatory drugs. Prior authorization is not required for patients established on a single-source nonsteroidal anti-inflammatory product before October 1, 1992.

Prior authorization is required for single-source nonsteroidal anti-inflammatory drugs. Included in the definition of 'single-source' is the innovator of a multiple-source drug, or "brand name." Payment will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least two multiple-source nonsteroidal anti-inflammatory drugs.

One a prior authorization has been issued for the single-source nonsteroidal anti-inflammatory drug, the drug may be changed to another single-source product within the approved time period without a new request.

5. Vitamins and Minerals

Examples of drug products which fall in the category of legend and nonlegend multiple vitamins, tonic preparations, and combinations thereof with minerals, hormones, stimulants, or other compounds which are available as separate entities for treatment of specific conditions, are Berocca, Sigtabs, and Theragram Hematinic.

Prior authorization is not required for a product primarily classified as a blood modifier, if that product does not contain more than three vitamins. Some examples of products which are classified as blood modifiers under this definition are Fero-Folic 500, Perihemin, and Trinsicon. Prior authorization is not required for vitamin and mineral products principally marketed for use as a dietary supplement during pregnancy and lactation.

Payment for multiple vitamins will be authorized only for:

- Cases in which there is a diagnosis of specific vitamin-deficiency disease, or
- Patients age 20 and under with a diagnosed disease which inhibits the nutrition absorption process secondary to the disease.

The request must also state the reason that drugs now available for payment under Medicaid are not satisfactory for treatment of the condition.

6. Dipyridamole

Prior authorization is required for dipyridamole therapy, including the innovator of the multiple-source product and the multiple-source products. Payment will be authorized only where there is documentation of a medical contraindication of the use of aspirin.

7. Cephalexin Hydrochloride Monohydrate

Prior authorization is required for all cephalexin hydrochloride monohydrate therapy. Payment for will be authorized only when there is documentation of previous trial and therapy failure with cephalexin monohydrate.

8. Single-Source Benzodiazepines

Prior authorization is not required for multiple-source benzodiazepines. Prior authorization is not required for patients established on a single-source benzodiazepine product before October 1, 1992.

Prior authorization is required for single-source benzodiazepines. Included in the definition of single-source is the innovator of a multiple-source drug, or "brand-name." Payment will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least one multiple-source benzodiazepine product.

Prior authorization will be granted for 12 months for documented:

- Generalized anxiety disorder
- Panic attack with or without agoraphobia
- Seizure
- Nonprogressive motor disorder
- Bipolar depression
- Dystonia

Prior authorization will be granted for three months for all other diagnoses related to the use of benzodiazepines.

9. Legend Topical Anti-Acne Products

Prior authorization is not required for non-legend topical acne products for the treatment of acne vulgaris. Please consult the OTC payable list for current information on those covered products. Prior authorization for topical tretinoin products is discussed in the next subsection.

Prior authorization is required for all **legend** topical acne products for the treatment of acne vulgaris. The definition of legend topical acne products includes all topical products for the treatment of acne vulgaris, including multiple-source and single-source products. Payment will be authorized only for cases in which there is documentation of previous trial therapy failure with at least one non-legend benzoyl peroxide product.

10. Topical Tretinoin Products

Prior authorization is required for all topical tretinoin products. Additional examination will occur when the request is for a patient over 25 years of age. Payment will be authorized for the following diagnoses:

- Darter's disease
- Lamellar ichthyosis
- Skin cancer

Regardless of age, these diagnoses do not require previous trials and therapy failure with other legend or non-legend anti-acne products, and approval will be granted for lifetime use.

Payment for topical tretinoin product therapy will also be authorized for preponderance of comedonal acne. Regardless of age, this diagnosis does not require previous trial and therapy failure with other legend or non-legend anti-acne products, and approval will be granted for an initial three-month period. If topical tretinoin therapy is effective after the initial approval period, prior authorization will be granted for a one-year period.

E. Cost and Quantity Standards

You requested to cooperate with the Department in keeping the cost of drugs to a minimum, consistent with a good quality of patient care.

When a medication is available at several price levels, prescribe low-cost items whenever possible. In writing prescriptions, prescribe a 30-day supply, unless therapeutically contraindicated.

Exception: Maintenance drugs in the following classifications for use in prolonged therapy may be prescribed in 90-day quantities:

- Oral contraceptives
- Cardiac drugs (cardiotonic glycosides, digitalis, antiarrhythmic drugs)
- Hypotensive agents (captopril, enalapril, diltiazem, etc.)
- Vasodilating agents (nitroglycerin, isosorbide, etc.)
- Anticonvulsants (diphenylhydatoin, primidone, phenobarbital [as anticonvulsant only], etc.)
- Diuretics
- Anticoagulants
- Thyroid and antithyroid agents
- Antidiabetic agents

While additional reimbursement is not provided for unit-dose packaged medication, such medication may be used for Medicaid patients, particularly those in nursing care facilities.

Payment for drug products which have lower-cost equivalents available is limited to the average wholesale price of the equivalent product dispensed. "Equivalent products" are defined as those products which meet therapeutic equivalence standards as published in the U.S. Food and Drug Administration document, "Approval Prescription Drug Products with Therapeutic Equivalence Evaluations."

If a lower-cost equivalent product is not dispensed in place of a more expensive brand-name product, the maximum allowable reimbursable cost is 150 percent of the average wholesale price of the least costly equivalent product.

Procedures for exceptions to the maximum allowable cost are the same as those in effect for the Federal Maximum Allowable Cost Program, i.e., certification in the prescriber's own handwriting that in the prescriber's medical judgment a specific brand is medically necessary.

IV. BASIS OF PAYMENT FOR SERVICES

The basis of payment for services is a fee schedule. The fee schedule amount is a maximum payment amount, not an automatic payment. Reimbursement will be the lower of the customary charge or the fee schedule amount.

The charges for services provided to Medicaid recipients must not exceed the customary charges to private pay patients.

V. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). In submission of claims, use the applicable procedure code number and the terminology indicated below.

For services provided as a result of an EPSDT (early and periodic screening, diagnosis and treatment) examination, show modifier "Z1" after the procedure code.

A. Services

1. Office Services

Code	Procedure
99201	Office or other outpatient visit; new patient; requires: • a problem-focused history, • a problem-focused examination, and • straightforward medical decision making.
99202	Office or other outpatient visit; new patient; requires: • an expanded problem-focused history, • an expanded problem-focused examination, and • straightforward medical decision making.
99203	Office or other outpatient visit; new patient; requires: • a detailed history, • a detailed examination, and • medical decision making of low complexity.
99204	Office or other outpatient visit; new patient; requires: • a comprehensive history, • a comprehensive examination, and • medical decision making of moderate complexity.
99205	Office or other outpatient visit; new patient; requires: • a comprehensive history, • a comprehensive examination, and • medical decision making of high complexity.
99211	Office or other outpatient visit; established patient, may or may not require the presence of a physician.
99212	Office or other outpatient visit; established patient; requires at least two of these three components: • a problem-focused history, • a problem-focused examination, and • straightforward medical decision making.

Code	Procedure
99213	Office or other outpatient visit; established patient; requires at least two of these three components: • an expanded problem-focused history, • an expanded problem-focused examination, and • medical decision making of low complexity.
99214	Office or other outpatient visit; established patient; requires at least two of these three components: • a detailed history, • a detailed examination, and • medical decision making of moderate complexity.
99215	Office or other outpatient visit; established patient; requires at least two of these three components: • a comprehensive history, • a comprehensive examination, and • medical decision making of high complexity.

2. Hospital Care

Code	Procedure
99231	Subsequent hospital care, per day; requires at least two of these three components: • a problem-focused interval history, • a problem-focused examination, and • medical decision making that is straightforward or of low complexity.
99232	Subsequent hospital care, per day; requires at least two of these three components: • an expanded problem-focused interval history, • an expanded problem-focused examination, and • medical decision making of moderate complexity.

3. Office and Other Outpatient Consultations: New or Established Patients

Code	Procedure
99241	Office consultation; requires these three components: • a problem-focused history, • a problem-focused examination, and • straightforward medical decision making.
99242	Office consultation; requires these three components: • an expanded problem-focused history, • an expanded problem-focused examination, and • straightforward medical decision making.

4. Initial Inpatient Consultations: New or Established Patients

Code	Procedure
99251	Initial inpatient consultation; requires these three components: • a problem-focused history, • a problem-focused examination, and • straightforward medical decision making.
99252	Initial inpatient consultation; requires these three components: • an expanded problem-focused history, • an expanded problem-focused examination, and • straightforward medical decision making.

5. Emergency Department Services: New or Established Patients

Code	Procedure
99281	Emergency department visit; requires these three components: • a problem-focused history, • a problem-focused examination, and • straightforward decision making.

Code	Procedure
99282	Emergency department visit; requires these three components: • an expanded problem-focused history, • an expanded problem-focused examination, and • medical decision making of low complexity.
99283	Emergency department visit; requires these three components: • an expanded problem-focused history, • an expanded problem-focused examination, and • medical decision making of low to moderate complexity.

6. Nursing Facility Services

Code	Procedure
Y0040	Congregate nursing home visit
W0136	Mileage (one way to nursing home outside locality)
99301	Comprehensive nursing facility assessments; requires these three components: • a detailed interval history, • a comprehensive examination, and • medical decision making that is straightforward or of low complexity.
99311	Subsequent nursing facility care, per day; requires at least two of these components: • a problem-focused interval history, • a problem-focused examination, and • medical decision making that is straightforward or of low complexity.
99312	Subsequent nursing facility care, per day; requires at least two of these three components: • an expanded problem-focused interval history, • an expanded problem-focused examination, and • medical decision making of moderate complexity.

7. Residential Care Services: New Patient

Code	Procedure
99321	Domiciliary or rest home visit; requires these three components: • a problem-focused history, • a problem-focused examination, and • medical decision making that is straightforward or of low complexity.
99322	Domiciliary or rest home visit; requires these three components: • an expanded problem-focused history, • an expanded problem-focused examination, and • medical decision making of moderate complexity.

8. Residential Care Services: Established Patient

Code	Procedure
99331	Domiciliary or rest home visit; requires these three components: • a problem-focused interval history, • a problem-focused examination, and • medical decision making that is straightforward or of low complexity.
99332	Domiciliary or rest home visit; requires these three components: • an expanded problem-focused interval history, • an expanded problem-focused examination, and • medical decision making of moderate complexity.
99333	Domiciliary or rest home visit; requires these three components: • a detailed interval history, • a detailed examination, and • medical decision making of high complexity.

9. Home Services

Code	Procedure
99341	Home visit, new patient; requires these three components: • a problem-focused history, • a problem-focused examination, and • medical decision making that is straightforward or of low complexity.
99342	Home visit, new patient; requires these three components: • an expanded problem-focused history, • an expanded problem-focused examination, and • medical decision making of moderate complexity.
99351	Home visit, established patient; requires these three components: • a problem-focused interval history, • a problem-focused examination, and • medical decision making that is straightforward or of low complexity.
99352	Home visit, established patient; requires these three components: • an expanded problem-focused interval history, • an expanded problem-focused examination, and • medical decision making of moderate complexity.

10. Surgical Care

Code	Procedure
X1751	Partial excision of nail and nail matrix, per toe, for permanent removal
X1752	Complete simple excision of nail (e.g., ingrown or deformed), per toe, without permanent removal
11750	Complete excision of nail and nail matrix for permanent removal, per toe
11700	Manual debridement of nails, five or less *
11701	Debridement of additional nail, five or less *
11710	Debridement of nails, electric grinder; five or less *
11711	Debridement of additional nails, electric grinder, five or less *

* Only one form of debridement (manual or electric grinder) is payable on the same foot per day of services

The CPT manual provides additional codes which may be used as appropriate for services provided. Surgical guidelines are found in the CPT code book.

Further clarification of separate procedure: When there is more than one code that describes an integral part of the total service being provided, use the code that most closely describes the total procedure on the claim. The use of multiple codes in this situation is considered "fragmenting" charges.

B. Materials

1. Orthotic Appliances

Code	Procedure
W0303	Durable planter foot orthotic
W0304	Plaster impression for foot orthotic
W0305	Molded digital orthotic

2. Shoe Padding

Code	Procedure
L3300	Lift elevation, heel, tapered to metatarsals, per inch
L3310	Lift elevation, heel and sole, neoprene, per inch
L3320	Lift elevation, heel and sole, cork, per inch
L3330	Lift elevation, metal extension, skate
L3332	Lift elevation, inside shoe, tapered, up to one-half inch
L3334	Lift elevation, heel, per inch
L3480	Heel, pad and depression for spur
L3485	Heel, pad, removable for spur

3. Custom-Made Shoes

Code	Procedure
L3230	Orthopedic footwear, custom shoes, depth inlay
L3250	Orthopedic footwear, custom-molded prosthetic shoe with removable inner mold, each
L3251	Foot, silicone shoe molded to patient model, each
L3252	Foot, custom-fitted
L3253	Foot, custom-fitted, plastazote (or similar) molded shoe, each

I. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**OPTIONAL** – Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** – Enter the recipient's Medicaid ID number found on the *Medical Assistance Eligibility Card*. It should consist of seven digits followed by a letter, i.e., 1234567A.
2.	PATIENT'S NAME	**REQUIRED** – Enter the last name, first name and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim.

4.	INSURED'S NAME	**CONDITIONAL*** – If the recipient is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident. **Note:** This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.
5.	PATIENT'S ADDRESS	**OPTIONAL** – Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**CONDITIONAL*** – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation.
7.	INSURED'S ADDRESS	**CONDITIONAL*** – Enter the address and phone number of the insured person indicated in field number 4.
8.	PATIENT STATUS	**OPTIONAL** – Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**CONDITIONAL*** – If the recipient carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program.
10.	IS PATIENT'S CONDITION RELATED TO	**CONDITIONAL*** – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** – No entry required.

11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**CONDITIONAL*** – This field continues with information related to field 4. If the recipient is covered under someone else's insurance, enter the policy number and other requested information as known.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**CONDITIONAL** – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check "YES" and enter payment amount in field 29. If you have received a denial of payment from another insurance, check <u>both</u> "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
14.	DATE OF CURRENT ILL-NESS, INJURY, PREGNANCY	**CONDITIONAL*** – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS…	**CONDITIONAL** – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required.
16.	DATES PATIENT UNABLE TO WORK…	**OPTIONAL** – No entry required.

17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL** – Required if the referring physician does not have a Medicaid number.
17a.	ID NUMBER OF REFERRING PHYSICIAN	**CONDITIONAL*** – If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number. If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician. If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number.
18.	HOSPITALI-ZATION DATES RELATED TO…	**OPTIONAL** – No entry required.
19.	RESERVED FOR LOCAL USE	**REQUIRED** – If the patient is pregnant, write "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** – No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** – Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses.
22.	MEDICAID RESUBMISSION CODE…	**OPTIONAL** – No entry required.
23.	PRIOR AUTHORIZATION NUMBER	**CONDITIONAL*** – Enter the prior authorization number issued by Consultec.

24. A	DATE(S) OF SERVICE	**REQUIRED** – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED** – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – partial hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-stage Renal Disease Treatment 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility

24. C	TYPE OF SERVICE	**OPTIONAL** – No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged.
24. E	DIAGNOSIS CODE	**REQUIRED** – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. DO NOT write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** – Enter the usual and customary charge for each line item.
24. G	DAYS OR UNITS	**REQUIRED** – Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**OPTIONAL*** – Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	EMG	**OPTIONAL** – No entry required.
24. J	COB	**OPTIONAL** – No entry required.
24. K	RESERVED FOR LOCAL USE	**CONDITIONAL*** – Enter the treating provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** – No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.

27.	ACCEPT ASSIGNMENT?	**OPTIONAL** – No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**CONDITIONAL*** – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim.
30.	BALANCE DUE	**REQUIRED*** – Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	NAME AND ADDRESS OF FACILITY…	**CONDITIONAL** – If other than a home or office, enter the name and address of the facility where the service(s) were rendered.
33.	PHYSICIAN'S, SUPPLIER'S BILLING NAME…	**REQUIRED*** – Enter the complete name and address of the billing physician or service supplier.
	GRP #	**REQUIRED** – Enter the seven-digit Iowa Medicaid number of the billing provider. If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line.
BACK OF FORM	NOTE	**REQUIRED** – The back of the claim form must be intact on every claim form submitted.

B. Facsimile of Claim Form, HCFA-1500 (front and back)

(See the following pages.)

II. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following page.)

Page 14 was intentionally left blank.

C. Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

13. Total amount of Medicaid reimbursement as allowed for this claim.

14. Total amount of recipient copayment deducted from this claim.

15. Medical record number as assigned by provider; 10 characters are printable.

16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of *Remittance Advice* for explanation of the EOB code.

17. Line item number.

18. The first date of service for the billed procedure.

19. The procedure code for the rendered service.

20. The number of units of rendered service.

21. Charge submitted by provider for line item.

22. Amount applied to this line item from other resources, i.e., other insurance, spenddown.

23. Amount of Medicaid reimbursement as allowed for this line item.

24. Amount of recipient copayment deducted for this line item.

25. Treating provider's Medicaid (Title XIX) number.

26. Allowed charge source code:

B Billed charge
F Fee schedule
M Manually priced
N Provider charge rate
P Group therapy
Q EPSDT total screen over 17 years
R EPSDT total under 18 years
S EPSDT partial over 17 years
T EPSDT partial under 18 years
U Gynecology fee
V Obstetrics fee
W Child fee

27. Remittance totals (found at the end of the *Remittance Advice*):

- Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
- Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
- Number of denied original claims and amount billed by provider.
- Number of denied adjusted claims and amount billed by provider.
- Number of pended claims (in process) and amount billed by provider.
- Amount of check.

28. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

August 10, 1994

For Human Services Use Only

General Letter No. 8-A-AP(II)-530

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

PODIATRIC SERVICES MANUAL TRANSMITTAL NO. 94-1

Subject: Podiatric Services Manual, "Table of Contents," pages 4 and 5, revised; and Chapter E, "Coverage and Limitations," pages 1 through 13, revised; and pages 14 through 26, new.

This revision makes the following changes:

- Debridement of nails has been expanded to include the specific nail pathologies that are appropriate for this treatment.
- Surgical procedures have been added to advise providers to use the CPT code book for surgical guidelines.
- The section on treatment of pes planus refers the provider to Section II, item A, for a list of orthotic appliances.
- Routine foot care has been expanded to include a list of the possible diagnoses eligible for coverage of routine foot care.
- Payment for orthopedic shoes is being clarified.
- The nonlegend drug list has been expanded.
- Reimbursement will be the lower of the customary charge or the fee schedule amount.
- Typographical errors are corrected in the section "Procedure Codes and Nomenclature."

Date Effective

January 1, 1994

Material Superseded

Remove from the Podiatric Services Manual and destroy:

Page	Date
Contents, pages 4 and 5	April 1, 1992
Chapter E:	
1-3	July 1, 1986
4	April 1 1992
4a	July 1, 1987
4b	February 1, 1988
5-12	April 1, 1992
13	July 1, 1991

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

October 28, 1994

For Human Services Use Only

General Letter No. 8-A-AP(II)-531

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

PODIATRIC SERVICES MANUAL TRANSMITTAL NO. 94-2

Subject: Podiatric Services Manual, Chapter F, "Billing and Payment," pages 5 and 7, revised.

These revisions to Chapter F clarify instructions for the HCFA 1500 claim form. Page 5 clarifies the circumstances to complete field 10.

Page 7 changes the requirement for a narrative description in field 21. A brief narrative description may be included, but is not required.

Date Effective

August 1, 1994

Material Superseded

Remove from the Podiatric Services Manual, Chapter F, pages 5 and 7, dated April 1, 1992, and destroy:

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

For Human Services use only:

General Letter No. 8-AP-94
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

December 21, 1998

PODIATRIC SERVICES MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Podiatric Services Manual***, Table of Contents (page 5), revised; Chapter F, *Billing and Payment*, pages 1 through 17, revised.

Chapter F is revised to update billing and payment instructions.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from the ***Podiatric Services Manual*** and destroy them:

Page	Date
Contents (page 5)	January 1, 1994
Chapter F	
1	April 1, 1992
2, 3	12/90
4-6	April 1, 1992
7	August 1, 1994
8-13	April 1, 1992
14	Undated
15-17	09/27/91
18, 19	April 1, 1992

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.